WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR HYPOGLYCEMICS FOR ADJUNCT THERAPY COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgment about the case. Prescribers and dispensing physicians are required to retain a completed copy of the form.

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy, HCF 11179. Pharmacy providers are required to use the PA/PDL for Hypoglycemics for Adjunct Therapy to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or by submitting a paper PA request.

Providers may submit PA requests on a PA/PDL form in one of the following ways:

1) For STAT-PA requests, pharmacy providers should call (800) 947-1197 or (608) 221-2096.

2) For paper PA requests by fax, pharmacy providers should submit a Prior Authorization Request Form (PA/RF), HCF 11018, and the appropriate PA/PDL form to Wisconsin Medicaid at (608) 221-8616.

3) For paper PA requests by mail, pharmacy providers should submit a PA/RF and the appropriate PA/PDL form to the following address:

   Wisconsin Medicaid
   Prior Authorization
   Ste 88
   6406 Bridge Rd
   Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 8, 1996, would be 09/08/1996).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PRESCRIPTION INFORMATION

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

Element 4 — Drug Name and Strength
Enter the drug name and strength.

Element 5 — Date Prescription Written
Enter the date the prescription was written.

Element 6 — Directions for Use
Enter the directions for use of the drug.

Element 7 — Name — Prescriber
Enter the name of the prescriber.

Element 8 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

- XX5555555 — Prescriber's DEA number cannot be obtained.
- XX9999991 — Prescriber does not have a DEA number.

These default codes must *not* be used for prescriptions for controlled substances.

Element 9 — Address and Telephone Number — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code, as well as the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION IIIA — CLINICAL INFORMATION FOR BYETTA
Include diagnostic and clinical information explaining the need for the product requested. In Elements 11 through 18, check "yes" to all that apply.

Element 10 — Diagnosis — Primary Code and/or Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must match the ICD-9-CM description.

Element 11
Check the appropriate box to indicate whether or not the recipient has a diagnosis of Type II diabetes.

Element 12
Check the appropriate box to indicate whether or not the recipient has failed to achieve adequate glycemic control despite individualized diabetic medication management, such as a sulfonyurea or metformin. If "yes" is checked, indicate the recipient's current medication therapy and most current Hemoglobin A1c (HbA1c).

Element 13
Check the appropriate box to indicate whether or not the recipient is receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator.

SECTION IIIB — CLINICAL INFORMATION FOR SYMLIN

Element 14
Check the appropriate box to indicate whether or not the recipient has a diagnosis of Type I or Type II diabetes.

Element 15
Check the appropriate box to indicate whether or not the recipient has failed to achieve adequate glycemic control despite optimal insulin management, including the use of meal time insulin. If "yes" is checked, indicate the recipient's current medication therapy, including insulin regimen.

Element 16
Check the appropriate box to indicate whether or not the recipient has any of the following: an HbA1c greater than 9 percent, recurrent severe hypoglycemia or hypoglycemic unawareness, or a diagnosis of gastroparesis. Indicate the recipient's most current HbA1c value. If the recipient has any of these conditions, the PA will be returned.

Element 17
Check the appropriate box to indicate whether or not the recipient is receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator.

Element 18 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 19 — Date Signed
Enter the month, day, and year the PA/PDL for Hypoglycemics for Adjunct Therapy was signed (in MM/DD/YYYY format).

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

Element 20 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC) for each drug.

Element 21 — Days' Supply Requested
Enter the requested days' supply.

Element 22 — Wisconsin Medicaid Provider Number
Enter the provider's eight-digit Wisconsin Medicaid provider number.

Element 23 — Date of Service
Enter the requested first date of service (DOS) for the drug or biologic. For STAT-PA requests, the DOS may be up to 31 days in the future or up to four days in the past.

Element 24 — Place of Service
Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
00	Not Specified
01	Home
04	Long Term/Extended Care
07	Skilled Care Facility
10	Outpatient

Element 25 — Assigned PA Number
Record the seven-digit PA number assigned by the STAT-PA system.

Element 26 — Grant Date
Record the date the PA was approved by the STAT-PA system.

Element 27 — Expiration Date
Record the date the PA expires as assigned by the STAT-PA system.

Element 28 — Number of Days Approved
Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 29
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may also be included here.